Annual Eligibility Review Form

To continue your Healthy Families health care coverage

Instructions

To continue Healthy Families coverage, you must fill out this form, include all required papers, and mail everything to us so that we receive it by

Questions?

*If you have any questions about the form, call Healthy Families: **1-888-439-4741,** Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.*

Mailing

Residence

Are your name and address right?

If any of this is wrong, please cross it out. Write the correct information next to it.

Family Member Number:

Home: Work: Message:

1. Children now in Healthy Families.

Do the children listed below still live in your household? If not, cross out their names.

Do any of the children have income? For example, child support. If so, write their income. You need to mail proof of income with this form. *If you have questions about income, see the **Family Members and Income** brochure that came with this form.*

Child in Healthy Families	Date of Birth	Relationship to	Child's monthly income, if any

2. Have any of these children received health insurance from an employer within the last 3 months? ❑ Yes ❑ No

If yes, which children?:_____

When did the insurance end? _____ Why did it end? _____

3. Income of Applicant and other adults.

Fill in the information below. You need to mail proof of income with this form. *If you have questions about income or about who counts as an adult living in the home, see the **Family Members and Income** brochure that came with this form.*

If the adults below do not live in the house, please cross them out and add the names of adults who live in the house.

Adult family member living in the house	**Relationship to**	**Relationship to children**	**Gross income amount** (income before taxes)	**How often do you get income?**
	Applicant	❑ Parent ❑ Stepparent ❑ Other_____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
		❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

4. Children living in the house who are <u>not</u> in Healthy Families now.

- Cross out any children who don't live in the house anymore. Note: If a child is away at school and claimed as a tax dependent, the child is considered living at home.
- Fill in children's monthly income if they have income.
- Would you like any of these children to be in Healthy Families? Check the Yes box or the No box.
- If you want a child who is listed below to be in Healthy Families, you need to fill out an **Add a Person Form**.

Child *not* in Healthy Families	**Date of Birth**	**Relationship to**	**Child's monthly income, if any**	**Want child in Healthy Families?**
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

5. Have any of these children received health insurance from an employer within the last 3 months? ❑ Yes ❑ No

If yes, which children?:_____

When did the insurance end? _____ Why did it end? _____

6. Are there other children living in the house who are not listed in Questions 1 or 4?

- If there are other children in the house list them here. *If you have questions about who to list, see the **Family Members and Income** brochure that came with this form.*
- If anyone in the household is pregnant, write "Unborn child" in the Child area below.
- If you would like to apply for these people now, check the Yes box. You will need to fill out an **Add a Person Form**.

Child who *is not* in Healthy Families	Date of birth	Child's monthly income, if any	Relationship to	Want child in Healthy Families?
		$ Send proof of income	❑ child ❑ step child ❑ other	❑ Yes ❑ No
		$ Send proof of income	❑ child ❑ step child ❑ other	❑ Yes ❑ No
		$ Send proof of income	❑ child ❑ step child ❑ other	❑ Yes ❑ No

7. Is anyone in your household pregnant? ❑ Yes ❑ No

If yes, who? _____

Due Date: _____/_____/_____
mo / dd / yr

8. Income Deductions for expenses.

If you pay for child care or care for a person who is disabled, or if you pay court-ordered child support or alimony, you might be able to subtract (deduct) those costs from your household income. Fill in the information below. Only list expenses paid by the parents on this form. You need to mail proof of expenses with this form. Proof might be copies of your bills or copies of a court order. *If you have questions about deductible expenses, see the **Family Members and Income** brochure that came with this form.*

Child care expenses you pay each month for children under age 2. (The maximum amount allowed is $200.)	$ Send proof of expenses
Child care expenses you pay each month for children age 2 and over. (The maximum amount allowed is $175.)	$ Send proof of expenses
Disabled dependent care expenses you pay each month. (The maximum amount allowed is $175.)	$ Send proof of expenses
Monthly court ordered alimony you pay	$ Send proof of expenses
Monthly court ordered child support you pay.	$ Send proof of expenses
For each working parent, we will deduct up to $90 for work-related expenses.	

9. Healthy Families Notices

Declarations

I declare that each person I am applying for:

- Is a resident of California
- Is not in jail or in a mental hospital
- Is not eligible for Medicare Part A and Part B
- Is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program, but the employer contribution for dependent(s) is less than $10.

I also declare that:

- All individuals listed on this form will follow the rules of participation, the utilization review process and the dispute resolution process of the plans in which the individual is enrolled.
- I have read and understand the Healthy Families Handbook. I understand what it says about each health, dental and vision plan and the benefits they offer. The handbook can be viewed at www.healthyfamilies.ca.gov.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this form. I understand that information provided by other state and federal health care programs will be used to see if the people I am applying for qualify for Healthy Families.
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or unless I am only applying for myself.
- I understand that the form will be sent to Medi-Cal if my income is below the Healthy Families guidelines. The Medi-Cal Program provides health care coverage for children who qualify for their programs. Medi-Cal will use this form and may request additional information to see if my children qualify for Medi-Cal.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

Privacy

The law requires you provide the information requested to apply for Healthy Families. (Title 10, CCR, § 2699.6600) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with the agencies and plans you want to enroll in.

Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board
Attn: HIPAA Coordinator
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

10. Declaration and Signature *(Required)*

I declare under penalty of perjury under California state law that I have read this form, the answers provided, and the documents enclosed, and to the best of my knowledge, they are correct and true. I have read and understand the Notices and Declarations above.

Applicant signs here: _____ Date: _____

11. Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

❑ Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this form. This permission ends when the program mails you its decision on your Annual Eligibility Review.

I certify that the CAA listed below helped me complete this form. This CAA helped me for free.

Applicant's Signature _____ Date:_____

CAA# _____ EE#_____

CAA's Signature _____ Date:_____

The state will not reimburse the EE unless the CAA fills out this section completely and correctly when the form is submitted.

12. Mail or fax the form to Healthy Families.

Mail this form, proof of income papers, and proof of expenses papers to:

Healthy Families
PO Box 138005
Sacramento, CA 95813-80005

Or, you can fax the form and papers to:

Fax: 1-866-848-4975 The fax number is free.

Write your Family Member Number on each paper you send. Your Family Member Number is: